DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/08/2011	
	PROVIDER OR SUPPLIER	ARE CENTER	8380 VI	ADDRESS, CITY, STATE, ZIP CO IRGINIA ST LLVILLE, IN46410	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F0000	Complaint IN00 Federal/State detailegations are complaint IN00 Federal/State Detailegations are complaint IN00 Federal/State Detailegations are complaint IN00 Survey dates: Survey date	:: 155650 00266950 nelyn Kulik, RN :	F0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2F7311

Facility ID:

000577

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
	or condition	155650	A. BUILDING B. WING		09/08/2011
NAME OF I	DROVIDED OR SUBDITIES			ET ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIER			VIRGINIA ST	
LINCOL	NSHIRE HEALTH C	ARE CENTER	MER	RRILLVILLE, IN46410	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
1710	Supplemental sar	<u> </u>	1710		DATE
	Suppremental	mpre. 2			
		es also reflect State accordance with 410 IAC			
	Cathy Emswiller RN				
F0314 SS=D	a resident, the factoresident who enterpressure sores do sores unless the indemonstrates that a resident having necessary treatment healing, prevent in sores from develobased on record facility failed to necessary treatment.	prehensive assessment of ility must ensure that a rs the facility without es not develop pressure ndividual's clinical condition they were unavoidable; and pressure sores receives ent and services to promote affection and prevent new ping. review and interview the ensure residents received ent and services to for 1 of 3 residents	F0314	F314 The filing of this plan of correction does not constitu	10/08/2011 te an
	reviewed with pr of 11 related to n restart nutritiona	essure ulcers in a sample ot obtaining orders to I supplements when the Imitted to the facility.		admission that the alleged deficiency exists. This plan correction is provided as evidence of the facility's de to comply with the regulation and to continue to provide quarter.	sire ons
	Findings include	:		care.	
	on 9/7/11 at 1:30 diagnoses includ	esident #G was reviewed p.m. The resident's ed, but were not limited er to the right hip, sepsis, m, anxiety, knee		1) Immediate actions taken those residents identified: The physician for Resident was contacted and orders we obtained to resume the multivitamin with mineral,	#G

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155650	- 1	LDING	00	09/08/2011
		100000	B. WIN		PRESIDENCE CONTROL CON	03/00/2011
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE RGINIA ST	
LINCOL	NSHIRE HEALTH C	ARE CENTER		1	LLVILLE, IN46410	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	,	(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
	contractures, atr	ial fibrillation, and			Promod and Vitamin C.	
	gastroesophagea	· ·				
					2) How the facility identifie	d
	The resident was admitted to the facility				other residents:	
	on 7/12/11. An	admission note dated				
	7/12/11 at 22:36	(10:36 p.m.), indicated a			An audit has been completed	to
	skin assessment was completed with a pressure area on the right hip measuring				identify any other residents	tho
					re-admitted to the facility in last 30 days with pressure so	I
	_	ters) by 5.5 cm by 0.2 cm.			to ensure that all nutritional	
	and a pressure area to the right ischial				interventions were resumed	upon
		ring 0.4 cm by 0.4 cm.			re-admission.	T
	A pressure wour	nd assessment dated			3) System in place:	
	7/18/11, indicate	ed a pressure area to the				
	right hip measur	ing 7.3 cm by 6.1 cm by			Licensed Nurses will be	
		a was a Stage III,			re-educated on completing	
	indicated full thi	ckness tissue loss.			re-admission orders, includir	ıg
					reviewing medications and nutritional interventions for	
	A progress note	dated 7/20/11 at 16:21			wound healing ordered prior	to
	(4:21 p.m.), indi	cated that was a			hospital admission and notify	l l
	dietary-nutrition	al risk assessment. The			physician to obtain orders.	
	1	mended to provide diet per			, * *	
		kes at lunch and supper,			Director of Nursing/Designe	e
	and change the	Thera multivitamin to a			and Dietary Manager/Design	ee
	multivitamin wit	th minerals and add 30 ml			will review orders of all	
	(milliliters) of Pa	romod (nutritional			re-admissions and compare	
	supplement) twi	ce a day and 500 mg			orders with previous orders t	•
		Vitamin C twice a day for			ensure nutritional intervention and medications for wound	ns
	wound healing.	-			healing are continued as order	ered
					by physician.	/10u
	A progress note	dated 7/20/11 at 18:21			oj prijoremi.	
	(6:21 p.m.), indi	cated the nurse spoke to			The Dietician will provide th	ie
		d related the dietary			Director of Nursing/Designe	I
		s. A new order was			copy of all recommendations	<u>, </u>

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X			(X2) MULTIPLE CONSTRUCTION (X			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155650	B. WIN			09/08/2	011
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R		1	RGINIA ST		
LINCOL	NSHIRE HEALTH C	ARE CENTER		1	LLVILLE, IN46410		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	.	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		ted to change the Thera			given to nursing to ensure		
		a multivitamin with			appropriate follow-up. The		
		g of Vitamin C twice a			Wound Nurse will also be g		
	day, 30 ml of Promod twice a day with				copy of all recommendation related to residents with wor		
	med pass and health shake at lunch and						
	supper.				The Dietary Manager/Desig will follow-up with nursing	nee	
					managers and the Director of	.f	
	A wound assessment dated 8/8/11,				Nursing/Designee after	71	
	indicated the resident had a Stage III to				recommendations are made	to	
	the right hip measuring 6.0 cm by 4.2 cm				ensure that recommendation		
	by 1.2 cm. There was a Stage II (partial				were received and implemen		
	thickness loss of dermis presenting as a				The Dietary Manager/Desig		
		cer with a red pink ulcer			will ensure that recommend		
	_	3.0 cm by 2.0 cm by 0.3			are completed timely and		
	1 '	•			documentation of current		
	1	schial (buttock). There			nutritional wound healing		
		to the left ischial area.			interventions is accurate.		
		improving and there were					
		cial areas noted to the			The results of these audits w	ill be	
	ischial regions.				forwarded to the Quality		
					Assurance Committee for re	eview	
		er dated 8/8/11, indicated			and any concerns will be		
		ent to the emergency			addressed.		
	room for evaluation	tion and treatment.					
					4) How the corrective action	ons	
	An admission no	ote dated 8/11/11 at 19:30			will be monitored:		
	(7:30 p.m.) indic	cated the resident had a					
		the right hip measuring 6			The Director of		
	1 ^	was a Stage III. The right			Nursing/Designee will be	4.	
	ischial, penis and	_			responsible for the coordina	uon	
	excoriated.				and monitoring of audits.		
					The Director of		
	A progress note	dated 8/11/11 at 19:30			Nursing/Designee will prese	ant	
		cated the resident was			the results of the audits to the		
					Quality Assurance Committ		
	readmitted to the	e facility. The resident had			Quanty Assurance Committe	<u></u>	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155650	B. WIN			09/08/2	011
		1	P		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			RGINIA ST		
	NSHIRE HEALTH C			1	LLVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	-	LSC IDENTIFYING INFORMATION)	+	TAG	·		DATE
		ure area to his right hip. It			monthly.		
	was cleansed and covered with a dry				· · · · · · · · · · · · · · · · · ·		
	dressing. The physician was notified and				5. Date of compliance:		
	indicated to follo	ow hospital orders.			10/0/11		
					10/8/11		
	A wound assess	ment dated 8/29/11,					
	indicated the rig	ht hip wound measured					
	3.9 cm by 2.4 cm	n by 1.5 cm. The right					
	1	13.0 cm by 2.0 cm by 1.2					
		excoriation to the left					
		e wounds were improving					
		lation tissue present.					
	with more grand	nation tissue present.					
	A progress note	dated 9/2/11 at 16:58					
		cated dietary progress					
	1 ' '	ent received Tab-a -vite to					
	_	at may better benefit from					
		vith minerals, 30 ml					
		day and 500 mg Vitamin					
	1	r increased healing					
	1 -	nt hip wound had					
	1	gth and width since last					
	evaluation but ha	ad increased in depth.					
	Review of the A	ugust 11, 2011 and the					
	September 2011	Physician Order					
	Statement, indic	ated the resident did not					
	have an order fo	r the multivitamin with					
	mineral, 30 ml o	of Promod twice a day and					
	1 '	nin C twice a day.					
		· J ·					
	Review of the A	ugust 11, 2011 and					
	September 2011	•					
	1 ^	Record, indicated the					
		Accord, murcated tile					

	li i			ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155650	A. BUI	LDING	00	COMPL 09/08/2	
		199090	B. WIN			09/06/2	011
NAME OF	PROVIDER OR SUPPLIE	₹		1	DOINHA OT		
LINCOL	NSHIRE HEALTH C	ARE CENTER			RGINIA ST _LVILLE, IN46410		
				L	LEVILLE, HVTOT 10		(V.E.)
(X4) ID PREFIX	1	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	resident had not	been receiving a					
		th minerals, 30 ml					
		day and 500 mg Vitamin					
	1	nce he was readmitted					
	from the hospita						
	l see see see see see	- 2//					
	The Nurse Cons	ultant provided the					
	I .	ssment of Residents					
		edure on 9/8/11 at 4:15					
	1 *	se of the policy was "To					
	1 ^ ^	and procedure for the					
	1 -	sident's nutritional					
	status." The Cli	nical Dietitian will					
		onal status assessment for					
	all newly admitt						
	1	etitian will then perform a					
		sment within 14 days of					
		rding to the following					
	I .	guidelines included, but					
	1 -	to, all nutritional history					
	I .	inent to the resident's					
	1	ill be documented.					
	Jack Collection W						
	Interview with the	ne Director of Nursing on					
	9/8/11 at 9:35 a.:	· ·					
		ian should have been					
	1 .	art the multivitamin with					
		d, and the Vitamin C.					
	She indicated a i	·					
	I	had been made on 9/2/11					
		Hall Unit Manager's					
	1 *	ll Unit Manager had left					
	I	tion and had been called					
		7/11 when she found the					

li i		I I			(X3) DATE S	TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPLETED	
		155650	B. WING			09/08/20	011
NAME OF I	DROVIDED OD GUDDU IED		<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			8380 VII	RGINIA ST		
	NSHIRE HEALTH C				LVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	1	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
		on her desk. She					
		if the A Hall Unit					
	Manager had not been called in the						
	Dietary Manager would have informed						
	her on 9/7/11 of	the recommendation.					
	Interview with th	ne Director of Nursing on					
	9/8/11 at 9:40 a.1	m., indicated the resident					
	had not been on	those supplements in the					
	hospital and did	not return with an order					
	_	ents. She further indicated					
		inquired if the physician					
		the supplements.					
	,, will be to 100 with	the supplements.					
	Interview with th	ne Nurse Consultant on					
		m., indicated the policy					
	-	sessment was for new					
		idents who were being					
		e facility. There was no					
	policy for resider	nts who were readmitted.					
		relates to complaint					
	IN00095696 and	I IN00095938.					
	2.1.40(.)(2)						
	3.1-40(a)(2)						
F0332	The facility must e	ensure that it is free of					
SS=D	,	ates of five percent or					
	greater.						
		ation, record review and	F033	32	F332		10/08/2011
	interview, the fac	cility failed to remain free			m		
		rror rate of 5 percent or			The filing of this plan of		
	greater related to	giving medications after			correction does not constitute	an	
	a meal when pha	rmacy recommended on			admission that the alleged		

NAME OF PROVIDER OR SUPPLIER 155650 Name	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER SIMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) TAG an empty stomach and failing to give ordered medication for 1 of 11 sampled residents (Resident #D) and for 2 residents in the supplemental sample of 2 (Residents #M and Resident #O) during the observation of 3 of 4 medication administration passes. A total of 43 opportunities for error were observed. A total of 3 medication errors were observed. This resulted in a medication error rate of 6%. FINDINGS INCLUDED: 1. On 9/8/11 at 5:30 a.m. LPN #2 was observed preparing medications for Resident #N. The LPN placed one Levothyroxine (medication used to treat hypothyroidism) 50 meg (micrograms) in a medication cup. There were no other medication on ulcers) into a separate medication and diministration administration was administered at 1 g (gram)/ml (used to form a protective coating on ulcers) into a separate medications and poured a glass of water. At 5:35 a.m., the LPN penterod the resident's room and administered the two	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	I DING	00	COMPLETED	
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG an empty stomach and failing to give ordered medication for 1 of 11 sampled residents (Resident #D) and for 2 residents in the supplemental sample of 2 (Residents #N and Resident #O) during the observation of 3 of 4 medication administration passes. A total of 3 medication error rate of 6%. FINDINGS INCLUDED: 1. On 9/8/11 at 5:30 a.m. LPN #2 was observed preparing medications for Resident #N. The LPN placed one Levothyroxine (medication used to treat hypothyroidism) 50 meg (micrograms) in a medication cup. There were no other medications in the medication cup. She then poured 10 ml (milliliters) of Carafate 1 g (gram)/ml (used to form a protective coating on ulcers) into a separate medication cup. She put applesauce in the cup with the Levothyroxine medications and poured a glass of water. At 5:35 a.m. the LPN entered the resident's room and administered the two			155650				09/08/2011	
Same Virginia Structure Same Virginia St			l .	D. WIIV		ADDRESS CITY STATE ZIP CODE	<u> </u>	
MERRILLYILLE, IN46410 SUMMARY STATEMENT OF DEFICIENCIES TAG	NAME OF 1	PROVIDER OR SUPPLIEF	₹		1			
CAS ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX CEACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CONFIDENCE	LINCOLI	NSHIRE HEALTH C	ARE CENTER		1			
PREFIX TAG REGILATORY OR INC IDENTIFYING INFORMATION) an empty stomach and failing to give ordered medication for I of 11 sampled residents (Resident #D) and for 2 residents in the supplemental sample of 2 (Residents #N and Resident #O) during the observation of 3 of 4 medication administration passes. A total of 43 opportunities for error were observed. A total of 3 medication errors were observed. This resulted in a medication error rate of 6%. FINDINGS INCLUDED: 1. On 9/8/11 at 5:30 a.m. LPN #2 was observed preparing medications for Resident #N. The LPN placed one Levothyroxine (medication cup. She then poured 10 ml (milliliters) of Carafate 1 g (gram)/ml (used to form a protective coating on ulcers) into a separate medications and poured a glass of water. At 5:35 a.m. the LPN entered the resident's room and administered the two					L			
an empty stomach and failing to give ordered medication for 1 of 11 sampled residents (Resident #D) and for 2 residents in the supplemental sample of 2 (Residents #N and Resident #O) during the observation of 3 of 4 medication administration passes. A total of 43 opportunities for error were observed. A total of 3 medication errors were observed. This resulted in a medication error rate of 6%. FINDINGS INCLUDED: 1. On 9/8/11 at 5:30 a.m. LPN #2 was observed preparing medications for Resident #N. The LPN placed one Levothyroxine (medication cup. There were no other medications in the medication cup. She then poured 10 ml (milliliters) of Carafate 1 g (gram)/ml (used to form a protective coating on ulcers) into a separate medications and poured a glass of water. At 5:35 a.m. the LPN entered the resident's room and administered the two						PROVIDER'S PLAN OF CORRECTION		
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ordered medication for 1 of 11 sampled residents (Resident #D) and for 2 residents in the supplemental sample of 2 (Residents #N and Resident #O) during the observation of 3 of 4 medication administration passes. A total of 43 opportunities for error were observed. A total of 3 medication errors were observed. This resulted in a medication error rate of 6%. FINDINGS INCLUDED: 1. On 9/8/11 at 5:30 a.m. LPN #2 was observed preparing medications for Resident #N. The LPN placed one Levothyroxine (medication used to treat hypothyroidism) 50 mcg (micrograms) in a medication cup. There were no other medication in the medication cup. She then poured 10 ml (millilters) of Carafate 1 g (gram)/ml (used to form a protective coating on ulcers) into a separate medications and poured a glass of water. At 5:35 a.m. the LPN entered the resident's room and administered the two	IAG			+	IAG	•		
residents (Resident #D) and for 2 residents in the supplemental sample of 2 (Residents #N and Resident #O) during the observation of 3 of 4 medication administration passes. A total of 43 opportunities for error were observed. A total of 3 medication errors were observed. This resulted in a medication error rate of 6%. FINDINGS INCLUDED: 1. On 9/8/11 at 5:30 a.m. LPN #2 was observed preparing medications for Resident #N. The LPN placed one Levothyroxine (medication used to treat hypothyroidism) 50 meg (micrograms) in a medication cup. There were no other medication in the medication cup. She then poured 10 ml (milliliters) of Carafate 1 g (gram/ml (used to form a protective coating on ulcers) into a separate medication and to continue to provide quality care. 1) Immediate actions taken for those residents identified: As stated in the 2567, the medication Gemfibrozil for Resident #N was administered at 6:00 AM, not 6:00PM as stated in 2567. As stated in the 2567, the physician for Resident #O was notified, and an order was obtained to change the administration time of the Synthroid to 6:00 AM. As stated in the 2567, the physician for Resident #O was notified, and an order was obtained to change the administration time of the Synthroid to 6:00 AM. As stated in the 2567, the Physician for Resident #O was notified, and an order was obtained to continue to provide quality care. 1) Immediate actions taken for those residents identified: As stated in the 2567, the Physician for Resident #O was notified, and an order was obtained to continue to provide quality care. 1) Immediate actions taken for those residents identified: As stated in the 2567, the Physician for Resident #O was notified, and an order was obtained to change the administration time of the Synthroid to 6:00 AM. As stated in the 2567, the Physician for Resident #O was notified, and an order was obtained to change the administration time of the Synthroid to 6:00 AM. 9:55 AM.		1					51	
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incurcations.		medications.						
An audit was completed of all						_		
The record for Resident #N was reviewed residents receiving Synthroid to							I	
on 9/8/11 at 5:40 a.m. The Physician determine if any other residents		on 9/8/11 at 5:40	a.m. The Physician				nts	
,		Order Statement	dated September 2011,			were affected and no other		
la a a la		Order Statement	dated September 2011,			were affected and no other		

PRINTED: FORM APPROVED OMB NO. 0938-0391

09/26/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155650 09/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8380 VIRGINIA ST LINCOLNSHIRE HEALTH CARE CENTER MERRILLVILLE, IN46410 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE indicated the resident was to receive residents were identified. Gemfibrozil (medication used to treat 3) System in place: hyperlipidemia) 600 mg (milligrams) twice a day before meals at 6:00 a.m. and Licensed Nurses and QMA's will 1600 (4:00 p.m.). be re-educated on medication administration procedure, Review of the Medication Administration following manufacturer Record at 5:45 a.m., indicated the recommendations, and commonly Gemfibrozil had been signed out as given used medications requiring on 9/8/11 at 6:00 p.m. administration prior to meals. The Director of Interview with the A Hall Unit Manager Nursing/Designee will observe and LPN #1 at 6:00 p.m., indicated she medication administration on had not given the resident the medication varied shifts and provide further and was going to give her the medication education. Any issues identified at this time. will be addressed upon observation. The Director of 2. On 9/8/11 at 9:31:a.m. LPN #1 was Nursing/Designee will conduct observed preparing medications for these observations until all nurses Resident #O. The LPN placed one and QMA's have been observed. Synthroid (medication used to treat hypothyroidism) 25 mcg (micrograms), The Director of Nursing/Designee will review one Lisinopril/HCTZ (medication used to new orders during scheduled treat hypertension) 10/12.5 mg, and one morning meetings 5 days per Thera-M tablet in a medication cup. She week to ensure that medications then added applesauce to the medication requiring administration prior to cup. The LPN poured a glassed of water meals are scheduled at the and entered the resident's room at 9:35 appropriate times. a.m. and administered the medications. The consultant pharmacist will Interview with LPN #1 and Resident #O audit all resident's medication at this time indicated the resident had regimens monthly. Any eaten breakfast. recommendations will be forwarded to the Director of

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155650 09/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8380 VIRGINIA ST LINCOLNSHIRE HEALTH CARE CENTER MERRILLVILLE, IN46410 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Review of the label on the medication Nursing/Designee for appropriate action. card for the Synthroid 25 mcg, indicated one daily. A pharmacy sticker on the 4) How the corrective actions medication card indicated to be given on will be monitored: an empty stomach. The Director of The record for Resident #O was reviewed Nursing/Designee will be on 9/8/11 at 12:15 p.m. The Physician responsible for the coordination Order Statement for September 2011, of the consulting pharmacist's indicated Synthroid 25 mcg one tablet recommendations for appropriate orally once a day, to be given at 9:00 a.m. action. A summary of the pharmacist's Interview with the B Hall Unit Manager audits will be presented at the on 9/8/11 at 10:00 a.m., indicated most of **Quality Assurance Committee** the medications that were to be given on monthly. an empty stomach were scheduled at an earlier time than 9:00 a.m. 5. Date of compliance: Interview with LPN #1 on 9/8/11 at 10:30 10/8/11 a.m., indicated she had called the physician and obtained an order to change the administration time of the Synthroid to before breakfast. 3. On 9/8/11 at 9:50 a.m. QMA #1 was observed preparing medications for Resident #D. The QMA placed one Namenda (medication used for dementia) 10 mg (milligrams) in an medication cup. There were no other medications in the medication cup. She poured 60 ml (milliliters of Glucerna 2 Cal into a cup and poured a cup of water. At 9:55 a.m. she was administered the medication.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED			
		155650	A. BUILDING B. WING		09/08/2011	
	PROVIDER OR SUPPLIER		8380 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST LLVILLE, IN46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	Resident #D was Physician Order 2011, indicated the KCl (potassium of (milliequivalents ml daily. Interview with the on 9/8/11 at 10:4	45 a.m. the Record for reviewed and the Statement for September he resident was to receive chloride) 20 meq)/15 ml (milliliters) 15 The A Hall Unit Manager 7 a.m., indicated the regiven the resident the				
	potassium chlorid administer the mo	de and she would edication at this time.				
	3.1-25(b)(9) 3.1-48(c)(10)					
F0385 SS=D	a recommendation admitted to a facili remain under the o	personally approve in writing that an individual be ty. Each resident must care of a physician.				
	of each resident is and another physic care of residents we physician is unava Based on record facility failed to expersonal physician	supervised by a physician; cian supervises the medical when their attending	F0385	F385 The filing of this plan of correduces not constitute an admist that the alleged deficiency expension is pro-	sion kists.	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
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			B. WIN		DDDECC CITY CTATE ZID CODE	<u> </u>	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
		ADE OFFITED		1	RGINIA ST		
LINCOLI	NSHIRE HEALTH C	ARE CENTER		MERRII	LLVILLE, IN46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the physician rel	ated to a critically high			as evidence of the facility's		
	potassium level	for 1 of 5 residents			to comply with the regulation		
	reviewed for change in condition in the				to continue to provide qualit	y	
	sample of 11. (Resident #J, Physician #1				care.	_	
	1 * `	•			1) Immediate actions taker	for	
	and Medical Dir	rector)			those residents identified:		
					As stated in the 2567, Resid		
	Findings include	ed:			#J was sent to the hospital of 8/6/11.	וזכ	
					2) How the facility identifie	.d	
	The record for R	Resident #J was reviewed			other residents:	u	
		a.m. The resident's			No other residents had a cri	tical	
					lab result on 8/5/11.		
	1 ~	led, but was not limited			3) System in place:		
	to, open abdomi	nal wound, hypokalemia,			Licensed staff will be re-edu	ıcated	
	end stage renal of	lisease, esophageal reflux,			regarding physician notifica	tion	
	pneumonia, urin	ary tract infection,			and alternate physician		
	1 *	ition, and hypertension.			notification if the primary		
		ivion, unu ny pervension.			physician is unavailable or o		
	A 1-1-44 14	1.4.10/5/11 :1:4.1.			not respond in a timely man		
		dated 8/5/11, indicated a			Staff will be educated to not		
	1 ^	of 2.6. The reference			physician and if a response		
	range was 3.5 to	5.3. The lab test			received in a timely manner resident will be sent to the	trie	
	indicated the res	ults were "critical result			emergency room if the resid	lent's	
	called and read l	back: (name) 1324 (1:24			condition is determined to b		
	1	op of the lab result was			unstable.	-	
	1 * /	f 8/5/11 with a time of			Lab results will be reviewed	in	
					morning meeting to ensure		
		.). The bottom of the lab			prompt physician notification	١.	
		left two messages with			4) How the corrective action	ns	
	(Physician #1) a	nswering (sic), no			will be monitored:		
	response. (Med	ical Director's name)			Any issues with physicians		
	called, no respon	nse. Director of Nursing			returning calls in a timely ma		
	1	icated to send the resident			will be discussed with the M	edical	
	to the emergence				Director during the monthly	20	
	to the emergenc	y 100111, 0/0/11.			Quality Assurance Committee meeting for him to address		
	1.				his peers.	/VILII	
	1	dated 8/5/11 at 14:56			5) Date of compliance:		
	(2:56 p.m.), indi	cated Spoke with			10/8/11		
	Physician #1 con	ncerning resident, new					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE (COMPL 09/08/2	ETED	
		100000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	03/00/2	011
NAME OF I	PROVIDER OR SUPPLIEI	₹		1	RGINIA ST		
LINCOLI	NSHIRE HEALTH C	ARE CENTER		1	LLVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	ŧ		+	TAG	DEFICIENCY)		DATE
		discontinue foley					
		ey catheter care, basic					
	1 ^	(blood test), PT/INR					
	(prothrombin tin						
		time blood test for					
	J	lytes, albumin, complete					
		h differential bi-weekly,					
	1	ent with (Physician #2's					
	1 '	t's wife notified. At 17:00					
	(5:00 p.m.) Physician #1 was phoned and						
	a message was left on voice mail for a						
		updated on lab values. At					
) the lab results were					
	I -	ysician #1 was called and					
	_	eft on voice mail for a					
		updated on lab values. At					
	, ,) Physician #1 was					
	1 ^	essage was left on voice					
		call to be updated on lab					
	values.						
	A progress note	dated 8/6/11 at 17:51					
		cated the resident was in					
		sponsive. The resident					
	· ·	but is asymptomatic at					
		ontinue to monitor. Vital					
		l pressure-114/68,					
	temperature-97.	-					
	_	e 16. Physician #1 was					
	1 ^	vo messages with the					
		ce. Physician #1 had yet					
	_	f attempted to call the					
	_	r and was unsuccessful as					
		tor of Nursing was					
	well. The Direc	tor of Nursing was					

	OF CORRECTION	1 ′			NSTRUCTION 00	(X3) DATE : COMPL	
AND TEAN	or conduction	155650	A. BUILI			09/08/2	
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				RGINIA ST		
LINCOLN	NSHIRE HEALTH CA	ARE CENTER			LVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG		cated to send the resident		IAG			DATE
		he resident's wife was					
		:46 (6:46 p.m.) the					
		t the facility to transport					
		e hospital. The resident					
		ponsive. There was no					
	l '	this time. At 19:30 (7:30					
		Director returned the call					
	*	ical lab and was made					
		dent being sent out to the					
		30 (9:30 p.m.) Physician					
		related to the resident's					
	critical labs and	was made aware the					
	resident was sent	to the hospital.					
		-					
	The Nurse Consu	ıltant provided the					
	Administrative P	hysician Notification for					
	Change in Condi	tion Policy on 9/8/11 at					
	4:20 p.m. The po	olicy indicated, "The					
	following sympto	oms, signs and laboratory					
	values should pro	ompt immediate					
		e physician. Immediate					
	* *	physician should be					
		as possible, either directly					
		er. If you do not obtain a					
	_	e physician, call the					
	1 -	ate physician. If you still					
		response, notify the					
	Director of Nursi	ing for further					
	instruction."						
	Laboratory result	ts: Potassium under 3.0.					
	Interview with th	ne Nurse consultant on					
		m., indicated the staff did					
	7,0,11 at 4.23 p.1	ii., iiidicated tile stall ald					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
155650			B. WING 09/08/2011			011	
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN46410				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I	ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PRE	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE
	physician, Medic Director of Nursi indicated what in then indicated the to do in regards t	relates to complaint					
F0501 SS=D	The medical direct implementation of the coordination of Based on record facility failed to Director coordination in the sound to be residents review condition in the sound responding we reach the resident lab value. (Residual Director Findings included The record for Record	tor is responsible for resident care policies; and f medical care in the facility. review and interview, the ensure the Medical ated medical care for 1 of wed for change in sample of 11 related to when the facility could not t's physician for a critical dent #J, Physician #1 and	F050	1	F501 The filing of this plan of corredoes not constitute an admis that the alleged deficiency exthis plan of correction is provas evidence of the facility's doto comply with the regulations to continue to provide quality care. 1) Immediate actions taken those residents identified: As stated in the 2567, Reside #J was sent to the hospital of 8/6/11. The Administrator me with the Medical Director and instructed him on his responsibilities. 2) How other residents having the submission of the su	sion dists. vided esire s and for ent n et	10/08/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **2F7311**

Facility ID:

000577

If continuation sheet

Page 15 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D.			(X3) DATE S	3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BIIII	A. BUILDING 00		COMPLETED	
155650		B. WING 09/08/20		011			
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1	RGINIA ST		
LINCOLNSHIRE HEALTH CARE CENTER				1	LLVILLE, IN46410		
LINCOLI	NOTINE HEALTH C	ARE CENTER		IVIERNIL	LEVILLE, IN40410		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	\bot	TAG	+		
	to, open abdomin	nal wound, hypokalemia,			the potential to be affected	-	
	end stage renal d	lisease, esophageal reflux,		the same deficient practice will be identified and what			
		ary tract infection,					
	1 *	ition, and hypertension.			corrective actions will be		
		mon, and hypertension.			taken: No other residents had a crit		
		1 . 10/5/44					
		dated 8/5/11, indicated a			lab result on 8/5/11.		
	potassium level	of 2.6. The reference			 What Measures will be point of the property of the second of t		
	range was 3.5 to	5.3. The lab test			changes will be made to	•	
	indicated the results were "critical result called and read back: (name) 1324 (1:24				ensure that the deficient		
					practice does not recur:		
					Licensed staff will be re-educ	cated	
	p.m.)". At the top of the lab result was the faxed date of 8/5/11 with a time of 14:39 (2:39 p.m.). The bottom of the lab result indicated left two messages with (Physician #1) answering (sic), no response. (Medical Director's name) called, no response. Director of Nursing notified and indicated to send the resident				regarding physician notificati		
					and alternate physician		
					notification if the primary		
					physician is unavailable or d	oes	
					not respond in a timely manr		
					Staff will be educated to noti	-	
					physician and if a response i received in a timely manner		
				resident will be sent to the emergency room if the resident's			
	to the emergency room, 8/6/11.				condition is determined to be		
					unstable.	ĺ	
	A progress note	dated 8/5/11 at 14:56			Lab results will be reviewed	in	
	(2:56 p.m.), indicated Spoke with				morning meeting to ensure		
	Physician #1 cor	ncerning resident, new			prompt physician notification		
	order received to discontinue foley catheter and foley catheter care, basic				4) How the corrective action	ns	
					will be monitored to ensure		
	1	•			deficient practice will not re		
	metabolic panel (blood test), PT/INR (prothrombin time/International normalized ratio time blood test for clotting), electrolytes, albumin, complete blood count, with differential bi-weekly, make appointment with (Physician #2's				i.e., what quality assurance		
					program will be put into pla		
					Any issues with physicians n		
					returning calls in a timely ma will be discussed with the Me		
					Director during the Quality	- uicai	
					Assurance Committee meeti	na l	
	* * *	s's wife notified. At 17:00			for him to address with his po		
	'	ician #1 was phoned and			5) Date of compliance:		
		-			10/8/11		
	a message was left on voice mail for a						

f ·		IDENTIFICATION NUMBER			INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155650	A. BUI B. WIN	LDING G		09/08/2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
				1	RGINIA ST		
LINCOLNSHIRE HEALTH CARE CENTER				MERRII	LLVILLE, IN46410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAU		updated on lab values. At		IAU	,		DATE
	1	•					
	17:15 (5:15 p.m.) the lab results were received and Physician #1 was called and						
	a message was left on voice mail for a return call to be updated on lab values. At						
		.) Physician #1 was					
		essage was left on voice					
	1 ^	call to be updated on lab					
	values.	1					
	A progress note dated 8/6/11 at 17:51 (5:51 p.m.), indicated the resident was in						
	bed, alert and responsive. The resident						
	had a critical lab but is asymptomatic at						
	this time, will continue to monitor. Vital						
	signs were blood	d pressure-114/68,					
	temperature-97.	5, pulse 72, and					
	respirations were	e 16. Physician #1 was					
	called and left two messages with the answering service. Physician #1 had yet						
	_	f attempted to call the					
	Medical Director and was unsuccessful as well. The Director of Nursing was notified and indicated to send the resident to the hospital. The resident's wife was informed. At 18:46 (6:46 p.m.) the ambulance was at the facility to transport the resident to the hospital. The resident was alert and responsive. There was no distress noted at this time. At 19:30 (7:30						
	1 * /	Director returned the call					
	1	tical lab and was made					
	aware of the resident being sent out to the						
	hospital. At 21:30 (9:30 p.m.) Physician						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	00	COMPL		
155650			B. WIN	IG		09/08/2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE	-	
				1	RGINIA ST		
LINCOLNSHIRE HEALTH CARE CENTER				MERRII	LLVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	#1 returned call related to the resident's critical labs and was made aware the resident was sent to the hospital.						
		ıltant provided the					
		hysician Notification for					
		tion Policy on 9/8/11 at					
	4:20 p.m. The po	olicy indicated, "The					
	following sympto	oms, signs and laboratory					
	values should prompt immediate notification of the physician. Immediate						
	implies that the physician should be notified as soon as possible, either directly or by beeper/pager. If you do not obtain a response from the physician, call the designated alternate physician. If you still do not receive a response, notify the						
	Director of Nursi	•					
	instruction." Laboratory results: Potassium under 3.0. Interview with the Nurse consultant on 9/8/11 at 4:25 p.m., indicated the staff did what they policy indicated the called the physician, Medical Director, and the Director of Nursing. The policy does not indicated what immediately means. She then indicated the staff did what they were to do in regards to the policy. This federal tag relates to complaint						
	IN00095696 and	INUUU95938.					
	2.1.12(.)(5)						
	3.1-13(v)(5)						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155650		(X2) MULTIPLE CC A. BUILDING B. WING	00	l l	E SURVEY PLETED [2011			
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		